DCH-LNR-503 (04/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, Michigan 48909
(517) 335-0918

REGISTERED NURSE AND PRACTICAL NURSE RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Nursing. Questions regarding your application can be directed to the Michigan Board of Nursing at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send original application, with the proper fee, to the Board of Nursing. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. If your RN or LPN license expired within the last 3 years, complete the relicensure application and return it with the appropriate fee.

   a. Please submit the required 25 hours of continuing education earned within the 2-years preceding the date of the application for relicensure. Additional information about the continuing education requirements for Michigan are available on-line at www.michigan.gov/healthlicense.

   b. Please submit verification of licensure from any state where you hold or have ever held a permanent license to practice as an RN or LPN. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure Form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed. If you were licensed in a state that uses the Nursys verification system, you can register with Nursys by calling toll-free (866) 819-1700 or register on-line at www.nursys.com.

3. If your RN or LPN license expired more than 3 years ago and a permanent RN or LPN license is currently held in one or more states, complete the relicensure application and return it with the appropriate fee.

   a. Please submit the required 25 hours of continuing education earned within the 2-years preceding the date of the application for relicensure. Additional information about the continuing education requirements for Michigan are available on-line at www.michigan.gov/healthlicense.

   b. Please submit verification of licensure from any state where you hold or have ever held a permanent license to practice as an RN or LPN. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure Form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed. If you were licensed in a state that uses the Nursys verification system, you can register with Nursys by calling toll-free (866) 819-1700 or register on-line at www.nursys.com.

4. If your RN or LPN license expired more than 3 years ago but a permanent RN or LPN license is not currently held in another state, an applicant must take and pass the NCLEX along with completing the relicensure application and returning it with the appropriate fee.

   a. You must complete the NCLEX Examination Application and submit it to Pearson Professional Testing (PPT) by either using the address shown on the form or calling PPT at 1-866-496-2539. You may also register for the NCLEX examination on the Internet at www.vue.com/nclex. The NCLEX Bulletin can be downloaded at www.ncsbn.org. You will be sent an Authorization to Test by PPT along with instructions for scheduling your testing appointment **after** you have been made eligible to take the test by the Michigan Board of Nursing.

   b. You will be sent an Authorization to Test from the PTT after you have applied for the NCLEX and have been made eligible for the exam by the Michigan Board of Nursing. The Authorization to Test will include a telephone number for you to call to schedule your examination. Once you have received your Authorization to Test, you must sit for the examination within 90 days.

   c. ***If you will require special testing accommodations because of a disability, you must submit a letter that indicates what your disability is and what type of accommodations you are requesting. Also, we require that you send us documentation from a licensed health care provider that clearly states your diagnosis and includes copies of all supporting test findings and/or evaluations. In addition, you should send us documentation from your educational program that describes any accommodations that were provided to you during your education. These documents need to be submitted at the same time you send in this license application to DCH, Bureau of Health Professions, Attn: ADA Request, PO Box 30670, Lansing, MI 48909.***

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes before the exam date, notify the Board of Nursing in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, Application Section, PO Box 30193, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Nursing in writing to request a refund.

SINCE ALL NURSING LICENSES EXPIRE ON MARCH 31, ORIGINAL LICENSES ARE VALID TO THE FIRST MARCH 31 WHICH MAYBE A YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING (Check One Only):

☐ **R.N. Relicensure - Fee: $68.00 71-4704-656**

☐ **L.P.N. Relicensure - Fee: $68.00 71-4703-656**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date

Street Address

City	State	ZIP Code

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)

Has your Michigan nursing license been lapsed more than three years?

☐ Yes ☐ No

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period ?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

List each state(s) in which you hold or have ever held a permanent nursing license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each state board verify license directly to this board office. (Attach additional sheets if necessary)

State	License Number	Date of Issue	How obtained (Endorsement or examination)

If your license expired **WITHIN THE LAST 3 YEARS**, complete this form and return it along with the appropriate fee. In addition, please submit evidence that you have obtained 25 approved continuing education credits within the two years immediately preceding the application for relicensure.

If your license expired **MORE THAN 3 YEARS AGO**, please check the appropriate box below and follow the instructions given:

☐ 1. I do hold a current nursing registration or license in the following state:

_____

In addition, please submit evidence that you have obtained 25 approved continuing education credits within the two years immediately preceding the application for relicensure.

☐ 3. I do not hold a current nursing registration or license in another U.S. Jurisdiction and therefore, must take and pass the NCLEX examination.

For information regarding registering for the NCLEX, call NCS Pearson at 1-866-496-2539 or go to www.vue.com/nclex

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.